

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

27982

FILED AUG 19 1947

Registration District No. 199

Primary Registration District No. 1002

Registrar's No.

3354

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
525 Bales  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. (Specify whether  
In this community 10 years  
years, months or days)

3. (a) PRINT  
FULL NAME

Winifred Vetter

3. (b) If veteran,  
name war. no

3. (c) Social Security  
No. none

4. Sex fe 5. Color or race white  
6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife George 6. (c) Age of husband or wife if  
alive. years  
7. Birth date of deceased November 19 1861  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
85 8 17 hr. min.

9. Birthplace Ireland  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Tague Ward

13. Birthplace Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. F. Beyman

(b) Address 525 Bales

17. (a) Removal (b) Date thereof 8-7-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Calvary - Topeka Kans.

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.

(b) Address 2825 Independence Blvd.

19. (a) 8-7-47 (b) Shelding Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 525 Bales  
(If rural, give location)  
(e) Citizen of foreign country? unknown (Yes or No)  
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 6  
year 1947 hour 7 minute 10 A. M.

21. I hereby certify that I attended the deceased from 8-2-47  
to 8-6-47  
that I last saw her alive on 8-2-  
and that death occurred on the date and hour stated above.

Immediate cause of death

Coronary Thrombosis Duration 5 days

Due to myocardiosis 2 mo

Due to Generalized arterial-  
sclerosis years

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations

Of autopsy

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur?  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature Thos. P. McCal (M.D. or other)  
Address 2620 Ind. Ave. Date signed 8-7-47

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

*Dr. McHale  
Indep. + Law*

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *H. D. Blackman* .....

Licensed Embalmer No. *3639* .....

P. O. Address *KC, Mo.* .....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**